

Prior Authorization Criteria (Commercial) — Effective July 1, 2007

Please note: This list is subject to change. As drugs change on the list, the prior authorization list is updated via Epocrates®, NaviNet®, our website (www.ibx.com/providers), and *Partners in Health Update*. Please visit www.ibx.com/medpolicy for detailed information on our pharmacy policies.

Name of drug/class	Approval criteria
Amevive®/Raptiva®	<ul style="list-style-type: none"> ▪ Documentation of moderate-to-severe chronic plaque psoriasis ▪ Failure, medical contraindication, or intolerance to two or more treatment modalities, including topical steroids, antipsoriatic agents, retinoids, and phototherapy ▪ Prescribed and/or administered by a dermatologist or rheumatologist ▪ Age of at least 18 years.
<p>Angiotensin II Receptor Blockers</p> <p>Benicar®/Benicar HCT®</p> <p>Diovan®/Diovan HCT®</p> <p>Atacand®/Atacand HCT®</p> <p>Avapro®/Avalide®</p> <p>Cozaar®/Hyzaar®</p> <p>Micardis®/Micardis HCT®</p> <p>Teveten®/Teveten HCT®</p>	<p>DIOVAN/DIOVAN HCT, BENICAR/BENICAR HCT (for new starts only):</p> <ul style="list-style-type: none"> ▪ Documentation of a minimum 30-day trial and failure of or intolerance to at least one angiotensin converting enzyme (ACE) inhibitor-containing product (e.g., enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months ▪ Diagnosis of Type 2 diabetes with renal insufficiency <p>AVAPRO/AVALIDE, ATACAND/ATACAND HCT, COZAAR/HYZAAR, MICARDIS/MICARDIS HCT, TEVETEN/TEVETEN HCT (for new starts only):</p> <ul style="list-style-type: none"> ▪ Documentation of a minimum 30-day trial and failure of or intolerance to valsartan (Diovan)- AND olmesartan (Benicar)-containing products <p>In addition, one of the following inclusion criteria must also be met in order for treatment with irbesartan (Avapro, Avalide), candesartan (Atacand/Atacand HCT), losartan (Cozaar, Hyzaar), telmisartan (Micardis/Micardis HCT), or eprosartan (Teveten/Teveten HCT) to be approved:</p> <ul style="list-style-type: none"> ▪ Documentation of a minimum 30-day trial and failure of or intolerance to at least one ACE inhibitor-containing product (e.g., enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months ▪ Diagnosis of type 2 diabetes with renal insufficiency <p>Addition to Policy: Patients requesting non-formulary Angiotensin II Receptor Blockers with documentation of Angiotensin Converting Enzyme Inhibitor use will receive authorizations for formulary Angiotensin II Receptor Blockers.</p>

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BiDil®	<ul style="list-style-type: none"> ▪ Diagnosis of heart failure ▪ Documentation of trial and failure or contraindication or intolerance to a combination isosorbide dinitrate and hydralazine product
Botox®/Myobloc®	Documentation of cervical dystonia, strabismus, blepharospasm, facial nerve disorders, focal and segmental limb dystonias, hemifacial spasm, focal hyperhidrosis, spastic hemiplegia, cerebral palsy, voice and speech disorders (abductor spasmodic dysphonia, adductor spasmodic dysphonia, laryngeal spasm, stuttering, and vocal tremor)
Byetta®	<ul style="list-style-type: none"> ▪ Documentation of concurrent use of metformin, a sulfonylurea, or combination of metformin and sulfonylurea <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of type 2 diabetes mellitus (DM)
Cesamet®	<ul style="list-style-type: none"> ▪ Documentation of chemotherapy-induced nausea and vomiting <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of trial and failure of ondansetron containing product (Zofran®) and one of the following: granisetron HCL (Kytril®) or aprepitant (Emend®)
COX-2 inhibitors (Celebrex®, Mobic®)	<p>For Celebrex</p> <ul style="list-style-type: none"> ▪ Documentation of familial adenomatous polyposis (FAP) <p>OR</p> <ul style="list-style-type: none"> ▪ Documentation of failure/contraindication to generic meloxicam and one of the following: <ul style="list-style-type: none"> ▪ The patient has a documented trial and failure of two non-steroidal anti-inflammatory drugs (NSAIDs) ▪ The patient is 65 years of age or older ▪ The patient has concurrent warfarin use (within the last 90 days) ▪ The patient has a bleeding disorder ▪ The patient is on concurrent systemic steroid treatment <p>OR</p> <p>Documentation of one of the following:</p> <ul style="list-style-type: none"> ▪ The patient has a history of gastrointestinal bleed, peptic ulcer, GERD, or Barrett's esophagus ▪ The patient has a documented concomitant condition in which a Celebrex offers a significant advantage over non-COX-2 selective NSAIDs and Mobic <p>For Brand Mobic</p> <ul style="list-style-type: none"> ▪ Documentation of trial/failure/contraindication to generic meloxicam

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Cymbalta®	<ul style="list-style-type: none"> ▪ Documentation of MDD OR GAD <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of the failure or intolerance to two of the following agents: <ul style="list-style-type: none"> – Bupropion – Bupropion sustained-release (SR) – Bupropion extended-release (XL) – Citalopram – Escitalopram (Lexapro®) – Fluoxetine – Fluvoxamine – Paroxetine – Sertraline – Venlafaxine (Effexor®) – Venlafaxine extended-release (Effexor® XR) ▪ Documentation of neuropathic pain associated with DPN secondary to diabetes with documented use of any diabetic medications
Daytrana®	<ul style="list-style-type: none"> ▪ Documented diagnosis of attention deficit hyperactivity disorder (ADHD) <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of either a trial and failure of, or intolerance to, at least two long-acting medications indicated for the treatment of ADHD
Enbrel®	<ul style="list-style-type: none"> ▪ Use in rheumatoid or psoriatic arthritis and rheumatoid variant conditions <p>AND</p> <ul style="list-style-type: none"> ▪ Prescribed by a rheumatologist or dermatologist (for psoriatic arthritis) <p>AND</p> <ul style="list-style-type: none"> ▪ Patient age at least 4 years
Erectile Dysfunction drugs (Viagra®, Caverject®, Edex®, MUSE®, Levitra®, Cialis®)	<ul style="list-style-type: none"> ▪ Documentation for erectile dysfunction in a male <p>AND</p> <ul style="list-style-type: none"> ▪ Absence of nitrate use during previous 6 months <p>AND</p> <ul style="list-style-type: none"> ▪ For males less than 55 years old, one of the following: <ul style="list-style-type: none"> – Concomitant conditions such as: diabetes, treatment for prostate cancer, pelvic surgery or radiation (i.e., colon cancer), spinal cord injury, or neurologic disease <p>OR</p> <ul style="list-style-type: none"> – Documented normal testosterone level

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Exjade®	<ul style="list-style-type: none"> ▪ Members age 2 years and older <p>AND</p> <ul style="list-style-type: none"> ▪ The diagnosis of chronic iron overload due to blood transfusions <p>AND</p> <ul style="list-style-type: none"> ▪ Serum ferritin levels consistently greater than 1000mcg/L (as demonstrated with at least two lab values within the previous two months) <p>AND</p> <ul style="list-style-type: none"> ▪ Evidence of failure/contraindication to deferoxamine injection
Exubera®	<ul style="list-style-type: none"> ▪ Documentation of assessment of pulmonary function test with $FEV_1 \geq 70\%$ <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of smoking abstinence or history of smoking greater than 6 months prior to treatment initiation <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of no current diagnosis of asthma, COPD, unstable or poorly controlled lung disease <p>AND one of the following:</p> <ul style="list-style-type: none"> ▪ Treatment of adult type I DM in combination with longer-acting insulin (NPH/Lantus) <p>OR</p> <ul style="list-style-type: none"> ▪ Treatment of adult type II DM
Fentora®	<ul style="list-style-type: none"> ▪ Diagnosis of breakthrough pain in patients with cancer who are already receiving opioid therapy ▪ Tolerance to current opioid therapy (therapy is defined as one of the following regimens for one week or longer): <ul style="list-style-type: none"> – At least 25 mcg of transdermal fentanyl hourly – At least 30 mg of oxycodone daily – At least 60 mg of oral morphine daily – At least 8 mg of oral hydromorphone daily – An equianalgesic dose of another opioid ▪ Trial and failure of generic oral transmucosal fentanyl citrate (Actiq®) for at least one week or longer

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Forteo®	<p>Individual who is 18 years of age or over and has documentation of primary (postmenopausal) or hypogonadal osteoporosis when all of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ The T score of the individual's bone mineral density (BMD) is at least -2.5 standard deviations below the young adult mean. ▪ The individual is receiving supplemental treatment with vitamin D and calcium. ▪ The individual has osteoporotic fractures, <i>or</i> ▪ Multiple risk factors for fractures, <i>or</i> ▪ The individual is intolerant of or failing to respond to at least one of the following therapies for osteoporosis: <ul style="list-style-type: none"> – Bisphosphonates (e.g., Boniva®, Fosamax®, Actonel®) – Hormone replacement therapy – Selective-estrogen receptor modulators (SERMs) (e.g., Evista®) – Calcitonin-salmon (Miacalcin®)
Gleevec®	<p>Documentation of one of the following diagnoses:</p> <ul style="list-style-type: none"> ▪ Acute lymphoblastic leukemia (ALL) ▪ Aggressive systemic mastocytosis (ASM) ▪ Chronic myeloid leukemia (CML) ▪ Dermatofibrosarcoma protuberans (DFSP) ▪ GI stromal tumors (GIST) ▪ Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia(CEL) ▪ Myelodysplastic/myeloproliferative diseases (MDS/MPD) ▪ Neoplastic disease with documentation of failure of conventional therapy
Glumetza®	<ul style="list-style-type: none"> ▪ Documentation of a trial and failure of or intolerance/allergy/contraindication to either metformin IR- or metformin ER-containing products ▪ Documentation of type 2 DM
Growth Hormone	<p>Documentation of the following diagnoses: Growth Hormone (GH) deficiency in children, Chronic Renal insufficiency, Turner Syndrome, Prader-Willi Syndrome, SGA, GH deficiency in adults with adult/childhood-onset hypothalamic or pituitary disease, AIDS wasting, hypopituitarism in childhood, neonates with suspected GH deficiency manifested by hypoglycemia, children with ISS with documentation of required laboratory tests</p>

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Humira®	<p>Adalimumab (Humira) is considered medically necessary and, therefore, covered for the following FDA-approved indications when prescribed by a rheumatologist or dermatologist:</p> <ul style="list-style-type: none"> ▪ Rheumatoid arthritis and age greater than 18 and prescribed by a rheumatologist ▪ Psoriatic arthritis and prescribed by a rheumatologist or a dermatologist ▪ Ankylosing spondylitis and prescribed by a rheumatologist <p>OFF-LABEL INDICATIONS FOR ADALIMUMAB (HUMIRA) Adalimumab (Humira) is considered medically necessary and, therefore, covered for the following off-label indications:</p> <ul style="list-style-type: none"> ▪ For reducing signs and symptoms of arthritis associated with all of the following conditions: inflammatory bowel disease, Crohn's disease, Reiter's syndrome, and other post-infectious syndromes. <p>Any other off-label indications for adalimumab (Humira) are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of these drugs for those indications cannot be established by a review of the available published medical literature.</p> <p>The use of adalimumab (Humira) with other TNF-blocking agents (e.g., infliximab, etanercept) or interleukin-1 (IL-1) inhibitors (e.g., anakinra [Kineret®]) is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this regimen cannot be established by a review of the available published medical literature.</p>
Invega®	<ul style="list-style-type: none"> ▪ Documented diagnosis of schizophrenia ▪ Documentation of a trial and failure of, or contraindication to, at least one of the following medications: <ul style="list-style-type: none"> – Arapiprazole (Abilify®) – Risperidone (Risperdal®) – Quetiapine fumarate (Seroquel®) – Olanzapine (Zyprexa®)
Iressa®	<p>Individuals who were documented as previously benefiting from gefitinib (Iressa) therapy prior to September 15, 2005, and have registered through the Iressa Access Program to continue therapy</p>
Januvia®	<ul style="list-style-type: none"> ▪ Documentation of type 2 DM ▪ Documentation of trial and failure or contraindication to metformin and either a thiazolidinedione (TZD) or a sulfonylurea

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Janumet®	<ul style="list-style-type: none"> ▪ Documentation of type 2 DM ▪ Documentation of one of the following: <ul style="list-style-type: none"> – Current concomitant therapy of both sitagliptin and metformin – Current treatment with metformin and trial/failure with one of the following: thiazolidinedione, sulfonylurea
Kineret®	<p>Anakinra (Kineret) is considered medically necessary and, therefore, covered for the following FDA-approved indication when prescribed by a rheumatologist:</p> <ul style="list-style-type: none"> ▪ Arthritis, rheumatoid <p>For reducing signs and symptoms and slowing the progression of structural damage in moderately to severely active rheumatoid arthritis (RA) in individuals 18 years of age or older who have failed one or more disease-modifying antirheumatic drugs (DMARDs). Anakinra (Kineret) can be used alone or in combination with DMARDs other than tumor necrosis factor (TNF)-blocking agents.</p> <p>OFF-LABEL INDICATIONS FOR ANAKINRA (KINERET)</p> <p>Anakinra (Kineret) is considered medically necessary and, therefore, covered for the following off-label indications:</p> <ul style="list-style-type: none"> ▪ For reducing signs and symptoms of arthritis associated with all of the following conditions: inflammatory bowel disease, Crohn's disease, Reiter's syndrome, and other post-infectious syndromes. <p>Any other off-label indications for anakinra (Kineret) are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of these drugs for those indications cannot be established by a review of the available published medical literature.</p>
Lipitor® and Caduet®	<p>Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to one of the following agents:</p> <ul style="list-style-type: none"> ▪ Lovastatin-containing product ▪ Pravastatin-containing product ▪ Simvastatin-containing product

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Lyrica®	<ul style="list-style-type: none"> ▪ Documentation of neuropathic pain that is associated with diabetic peripheral neuropathy ▪ Diagnosis of Fibromyalgia ▪ Add-on therapy for partial onset epileptic seizures in adults after trial and failure or contraindication/intolerance/allergy to Gabapentin ▪ Diagnosis of post herpetic neuralgia with trial and failure or contraindication/intolerance/allergy to Gabapentin ▪ Documentation of non diabetic neuropathic pain with a trial and failure or contraindication/intolerance/allergy to Gabapentin and at least one medication from three (3) of the following five (5) groups: <ul style="list-style-type: none"> – An opioid containing product – Tramadol – A tricyclic antidepressant – Lidoderm Patch or a form of topical lidocaine – Carbamazepine
Magnacet™	<ul style="list-style-type: none"> ▪ Documentation of the trial and failure/intolerance to an oxycodone/acetaminophen-containing product with 325 mg of acetaminophen ▪ Documentation of the reason why an oxycodone/acetaminophen-containing product with greater than 400 mg of acetaminophen would not be appropriate
Migraine agent quantity edit (Amerge®, Axert®, Frova®, Imitrex®, Maxalt®, Migranal®, Relpax®, Stadol®, Zomig®)	<ul style="list-style-type: none"> ▪ There is a documented diagnosis of migraine headaches. ▪ There has been a trial of prophylactic treatment with beta blockers, calcium channel blockers, tricyclic antidepressants, valproic acid, methysergide, cyproheptadine, etc. ▪ The requested quantity does not exceed the manufacturer-recommended maximum daily doses ▪ The individual has been examined by a neurologist within the past three years
Nexavar®	A diagnosis of advanced renal cell carcinoma
Noxafil®	<p>Individual who is 13 years of age or older and when either one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> ▪ Use in prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised state ▪ Use in the treatment of invasive Aspergillus and Candida infections due to a severe immunocompromised state after trial and failure of voriconazole (Vfend®) ▪ Diagnosis of oropharyngeal candidiasis with failed trials of itraconazole and fluconazole

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Nulev®	Documentation of intolerance to the standard dosage forms, or conditions that make swallowing tablets and liquid dosage forms difficult
Opana®/Opana ER®	<p>OXYMORPHONE (OPANA)</p> <ul style="list-style-type: none"> ▪ Documentation of the trial and failure of all oral Schedule II immediate-release (IR) opioid agonists indicated for moderate-to-severe pain, including: <ul style="list-style-type: none"> – Oxycodone – Oxycodone/acetaminophen – Aspirin/oxycodone – Codeine phosphate – Meperidine – Hydromorphone – Levorphanol tartrate – Morphine sulfate IR <p>OXYMORPHONE extended-release (ER) (OPANA ER)</p> <ul style="list-style-type: none"> ▪ Documentation of the trial and failure of all oral Schedule II ER opioid agonists indicated for moderate-to-severe pain, including: <ul style="list-style-type: none"> – Oxycodone ER – Morphine sulfate sustained-release (SR)
Oracea®	<ul style="list-style-type: none"> ▪ Documentation of diagnosis of Rosacea ▪ Documentation of trial and failure or contraindication/intolerance/allergy to topical metronidazole and one other formulation of oral doxycycline
Pataday™	<ul style="list-style-type: none"> ▪ Documentation of allergic conjunctivitis ▪ Documentation of trial and failure or contraindications to all of the following agents: olopatadine hydrochloride ophthalmic solution (Patanol™), azelastine hydrochloride ophthalmic solution (Optivar™), and ketotifen fumarate ophthalmic solution

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Paxil CR [®]	<ul style="list-style-type: none"> ▪ Documentation of a four week trial of two of the following medications, at least one of which is a Selective Serotonin reuptake inhibitor (SSRI): <ul style="list-style-type: none"> – A fluoxetine containing product – Paroxetine (Paxil[®]) – Citalopram (Celexa[®]) – Fluvoxamine (Luvox[®]) – Lexapro[®] – Sertraline (Zoloft[®]) – Venlafaxine (Effexor[®]) – Effexor XR[®] – Bupropion (Wellbutrin[®]) – Bupropion XL (Wellbutrin XL[®]) – Bupropion SR (Wellbutrin SR[®])
Proton Pump Inhibitors (Aciphex [®] , Prevacid [®] /Prevacid NapraPAC [®] , Nexium [®] , Protonix [®] , Pylera [®] , Zegerid [®])	<p>ESOMEPRAZOLE (NEXIUM) AND LANSOPRAZOLE (PREVACID)</p> <ul style="list-style-type: none"> ▪ Documentation of any of the indications specified for the drug ▪ A documented trial and failure or contraindication/intolerance/allergy to a prescription generic omeprazole lasting at least 14 days <p>ESOMEPRAZOLE (NEXIUM) FOR DELAYED-RELEASE ORAL SUSPENSION, LANSOPRAZOLE (PREVACID) ORALLY DISINTEGRATING TABLETS, AND LANSOPRAZOLE (PREVACID) GRANULES FOR ORAL SUSPENSION</p> <ul style="list-style-type: none"> ▪ The individual is under 12 years of age with documentation of any of the indications specified for the drug ▪ Documentation of the inability to swallow capsules/tablets (e.g., dysphagia, gastrointestinal [GI] tubes) along with documentation of any of the indications specified for the drug <p>LANSOPRAZOLE/NAPROXEN (PREVACID NAPRAPAC)</p> <ul style="list-style-type: none"> ▪ Documentation of any of the indications specified for lansoprazole/naproxen (Prevacid Naprapac) <p>RAPEPRAZOLE (ACIPHEX), PANTOPRAZOLE (PROTONIX), OMEPRAZOLE/SOD BICARBONATE (ZEGERID)</p> <ul style="list-style-type: none"> ▪ A documented trial of products containing esomeprazole (Nexium) AND lansoprazole (Prevacid) ▪ Documentation of any of the indications specified for the drug ▪ A documented trial and failure or contraindication/intolerance/allergy to a generic omeprazole lasting at least 14 days <p>BISMUTH SUBCITRATE POTASSIUM, METRONIDAZOLE, AND TETRACYCLINE HYDROCHLORIDE (PYLERA)</p> <ul style="list-style-type: none"> ▪ Documented diagnosis of <i>Helicobacter pylori</i>

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Provigil®	<p>Prescribed or recommended by a neurologist or sleep specialist, AND one of the following diagnoses with appropriate labs/clinical evaluations:</p> <p>Diagnosis of:</p> <ul style="list-style-type: none"> ▪ Narcolepsy, idiopathic hypersomnolence with documentation of a supporting-sleep study ▪ Documentation of fatigue associated with multiple sclerosis ▪ Diagnosis of shift work sleep disorder and clinical evaluation demonstrating the presence of a shift work schedule likely to result in sleepiness AND Failure of patient counseling regarding techniques for reducing the negative effects of shift work
Quaalun®	No documentation of uncomplicated <i>Plasmodium falciparum</i> malaria
Ranexa®	<ul style="list-style-type: none"> ▪ Documentation of insufficient response, intolerance, or contraindication to at least one medication from each of the following: <ul style="list-style-type: none"> – Long-acting nitrates (e.g., isosorbide dinitrate, isosorbide mononitrate) – Atenolol, metoprolol, nadolol, or propranolol – Nifedipine XL or amlodipine <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of concurrent treatment with one of the following: <ul style="list-style-type: none"> – Amlodipine – Beta-blocker – Long-acting nitrate
Revatio®	Documentation of pulmonary arterial hypertension and history of no nitrate prescriptions within the last six months
Revlimid®	<ul style="list-style-type: none"> ▪ Patients must be registered with RevAssistSM Program <p>AND</p> <ul style="list-style-type: none"> ▪ A diagnosis of transfusion-dependent anemia, due to low-or intermediate-1-risk myelodysplastic syndromes that are associated with a deletion 5q cytogenetic abnormality, with or without additional cytogenetic abnormalities <p>OR</p> <ul style="list-style-type: none"> ▪ A diagnosis of multiple myeloma in combination with dexamethasone for patients who had received at least one prior therapy (such as stem cell transplantation, thalidomide, dexamethasone, mephalan, doxorubicin, vincristine, cyclophosphamide, carmustine, Velcade®)

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Schedule II Oral Tablet/Capsule/ Lozenge Quantity Level Limit	Documentation of appropriate diagnosis upon visit with a qualified specialist, and evidence to support medical necessity of the requested dose
Singulair®	Documentation of asthma or diagnosis of allergic rhinitis plus failure with one prescription or over-the-counter non-sedating antihistamine (Allegra®/fexofenadine, Claritin®/loratadine, Clarinex®, Zyrtec®) or one intranasal steroid
Sleep agents (Ambien CR®, Lunesta®, Rozerem®)	<ul style="list-style-type: none"> ▪ Diagnosis of insomnia or chronic insomnia ▪ Documentation of a trial and failure of immediate release Zolpidem containing product for a minimum of 14 days within the past six months <p><i>Note:</i> Rozerem will be approved with a documented abuse potential</p>
Sprycel®	<ul style="list-style-type: none"> ▪ Documentation of chronic myeloid leukemia (CML) in any phase (chronic, accelerated, or myeloid or lymphoid blast phase) with resistance or intolerance to prior therapy, including Gleevec® (imatinib mesylate) <p>OR</p> <ul style="list-style-type: none"> ▪ Documentation of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) with resistance or intolerance to prior therapy
Sutent®	<ul style="list-style-type: none"> ▪ A diagnosis of gastrointestinal stromal tumors (GIST) after disease progression on or documented intolerance to imatinib mesylate (Gleevec®) ▪ A diagnosis of advanced renal cell carcinoma (RCC)
Symlin®	<ul style="list-style-type: none"> ▪ Documentation of type 1 diabetes with concurrent use of insulin therapy ▪ Documentation of type 2 diabetes with concurrent therapy with insulin or with a sulfonylurea agent and/or metformin with insulin
Tekturna®	<ul style="list-style-type: none"> ▪ Documented diagnosis of hypertension ▪ Documented trial and failure or contraindication/intolerance/allergy to an Angiotensin Converting Enzyme (ACE) inhibitor ▪ Documented trial and failure or contraindication/intolerance/allergy to Diovan® or Benicar® containing products (Diovan and Benicar require prior authorization per policy FS.CLIN.0.46) ▪ Documented trial and failure or contraindication/intolerance/allergy to an amlodipine containing product

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Thalomid®	<p>Documentation of one of the following diagnoses:</p> <ul style="list-style-type: none"> ▪ Acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) ▪ Maintenance therapy for prevention and suppression of erythema nodosum leprosum (ENL) occurrence ▪ First line therapy for multiple myeloma ▪ Neoplastic diagnosis with documentation of failure of conventional therapy
Tarceva®	<ul style="list-style-type: none"> ▪ The individual is diagnosed with locally advanced or metastatic non-small cell lung cancer (NSCLC) and has documentation of at least one prior chemotherapy regimen that failed or is contraindicated. ▪ The individual is diagnosed with locally advanced, unresectable or metastatic pancreatic cancer in combination with gemcitabine as a first-line therapy.
Ultram ER®	<ul style="list-style-type: none"> ▪ Trial and failure of tramadol AND at least one other generic analgesic medication indicated for moderate to moderately severe pain <p>AND</p> <ul style="list-style-type: none"> ▪ Age 18 years or older
Xolair®	<ul style="list-style-type: none"> ▪ Omalizumab (Xolair) treatment should be initiated by an allergist or pulmonologist. An allergist, pulmonologist, or primary care physician (PCP) can then prescribe omalizumab (Xolair) as maintenance therapy. ▪ Diagnosis of moderate to severe allergic asthma <p>AND</p> <ul style="list-style-type: none"> ▪ Individuals who are at least 12 years old <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen <p>AND</p> <ul style="list-style-type: none"> ▪ Documentation that symptoms are inadequately controlled with corticosteroids administered via inhaler <p>AND</p> <ul style="list-style-type: none"> ▪ Prescribed by or recommended by a pulmonologist, allergist
Zavesca®	<p>Documentation of mild to moderate type 1 (non-neuronopathic) Gaucher disease</p>
Zelapar®	<ul style="list-style-type: none"> ▪ Documentation of Parkinson's disease ▪ Documentation of the trial and failure of, intolerance to, or contraindication to other oral non-disintegrating formulations of selegiline HCl
Zmax®	<p>Documentation of contraindication to all other generic formulations of azithromycin</p>

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Zolinza®	<ul style="list-style-type: none"> ▪ Documentation of diagnosis of T-Cell Lymphoma with cutaneous manifestations ▪ Documentation of trial and failure or contraindication to at least two systemic therapies
Zyvox®	<ul style="list-style-type: none"> ▪ Prescribing physician must either be Infectious Disease (ID) specialist or has had ID consult <p>AND</p> <ul style="list-style-type: none"> ▪ Documented diagnosis of vancomycin-resistant Enterococcus faecium infection (VRE) <p>OR</p> <ul style="list-style-type: none"> ▪ Documented diagnosis of methicillin-resistant Staphylococcus aureus infection (MRSA) <p>Quantity Limit will be up to 28 doses. Requests for quantities greater than 28 are to be reviewed by a pharmacist/physician. The infective organism and infection site will determine the appropriate length of therapy.</p>